

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Willows Health Center# 0020792 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 1986

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>91</u>	Skilled (SNF)	<u>91</u>	<u>33,215</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>36</u>	Sheltered Care (SC)	<u>36</u>	<u>13,140</u>	5
6		ICF/DD 16 or Less			6
7	<u>127</u>	TOTALS	<u>127</u>	<u>46,355</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,821</u>	<u>26,846</u>		<u>31,667</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>229</u>	<u>11,601</u>		<u>11,830</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,050</u>	<u>38,447</u>		<u>43,497</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.83%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/01/1972

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified and days of care provided Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Willows Health Center # 0020792 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	472,057	70,902	83,437	626,396		626,396		626,396		1
2	Food Purchase		358,671		358,671	(4,201)	354,470		354,470		2
3	Housekeeping	145,594	20,628	1,344	167,566		167,566		167,566		3
4	Laundry	69,755	17,934	221	87,910		87,910		87,910		4
5	Heat and Other Utilities			192,474	192,474		192,474		192,474		5
6	Maintenance	171,575	27,172	196,047	394,794		394,794		394,794		6
7	Other (specify):* HR & MARKETING	42,200	90	8,208	50,498	(500)	49,998		49,998		7
8	TOTAL General Services	901,181	495,397	481,731	1,878,309	(4,701)	1,873,608		1,873,608		8
	B. Health Care and Programs										
9	Medical Director	24,191			24,191		24,191		24,191		9
10	Nursing and Medical Records	2,255,700	101,586	78,843	2,436,129	(3,151)	2,432,978		2,432,978		10
10a	Therapy										10a
11	Activities										11
12	Social Services	149,623	5,606	7,866	163,095		163,095		163,095		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,429,514	107,192	86,709	2,623,415	(3,151)	2,620,264		2,620,264		16
	C. General Administration										
17	Administrative	103,208			103,208		103,208		103,208		17
18	Directors Fees										18
19	Professional Services			40,712	40,712		40,712		40,712		19
20	Dues, Fees, Subscriptions & Promotions			8,095	8,095	500	8,595		8,595		20
21	Clerical & General Office Expenses	78,347	26,309		104,656		104,656		104,656		21
22	Employee Benefits & Payroll Taxes			654,365	654,365	4,201	658,566		658,566		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,549	3,549		3,549		3,549		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			18,000	18,000		18,000		18,000		26
27	Other (specify):* MISCELLANEOUS			31,830	31,830		31,830		31,830		27
28	TOTAL General Administration	181,555	26,309	756,551	964,415	4,701	969,116		969,116		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,512,250	628,898	1,324,991	5,466,139	(3,151)	5,462,988		5,462,988		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Willows Health Center

#0020792

Report Period Beginning:

07/01/01

Ending:

06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			253,724	253,724		253,724		253,724			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,062	22,062		22,062		22,062			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			275,786	275,786		275,786		275,786			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					3,151	3,151		3,151			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,823	49,823		49,823		49,823			42
43	Other (specify):* DEVELOPMENT			17,877	17,877		17,877	(17,877)				43
44	TOTAL Special Cost Centers			67,700	67,700	3,151	70,851	(17,877)	52,974			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,512,250	628,898	1,668,477	5,809,625		5,809,625	(17,877)	5,791,748			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	4,201	2-2		4
5	Telephone, TV & Radio in Resident Rooms	9,346	27-3		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	17,877	43-3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	2,719	7-3		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 34,143		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 34,143		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops	x		3,151	10-3	41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 3,151		47

Willows Health Center

ID# 0020792

Report Period Beginning: 07/01/01

Ending: 06/30/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/02

06/30/02

[illegible]

Summary B

06/30/02

[illegible]

Facility Name & ID Number Willows Health Center# 0020792

Report Period Beginning:

07/01/01

Ending:

06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Willows Health Center	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19-3	Management Fee	\$ 4,200	Wesley Willows	0.00%	\$ 4,200	\$ *	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 4,200			\$ 4,200	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Willows Health Center # 0020792 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Willows Health Center# 0020792 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE											
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)											
	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
	A. Directly Facility Related										
	Long-Term										
1	IL HEALTH FACILITY						\$			\$	1
2	IL# 697002		X	Personal Care Facility	n/a	12/6/86	2,000,000		paid off in April 2002	7.0000	22,062
3											3
4											4
5											5
	Working Capital										
6											6
7											7
8											8
9	TOTAL Facility Related						\$ 2,000,000	\$		\$ 22,062	9
	B. Non-Facility Related*										
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related						\$	\$		\$	14
15	TOTALS (line 9+line14)						\$ 2,000,000	\$		\$ 22,062	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>			
1. Real Estate Tax accrual used on 2001 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	8	
	1998	9	
	1999	10	
	2000	11	
	2001	12	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willows Health Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0020792

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,025 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	100,000	1974	\$ 14,007	1
2	Nursing Home	30,680	1994	7,729	2
3	TOTALS	130,680		\$ 21,736	3

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Willows Health Center

0020792

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	127	1986	1986	\$ 3,723,629	\$ 74,473	10-50	\$ 74,473		\$ 1,608,081
5									
6									
7									
8									
Improvement Type**									
9	roofing, intercoms, wanderguard	1987		77,240	2,783	10-40	2,783		55,993
10	wanderguard	1988		17,681	764	10-20	764		15,644
11	sidewalk & power door locks	1989		4,996	272	15-20	272		3,734
12	painting and papering, electrical	1990		15,333	258	10-20	258		12,987
13	exterior panels, courtyard, painting	1991		29,929	995	10-20	995		21,595
14	electric eye door	1992		12,830	661	10-20	661		6,906
15	painting	1993		5,321	71	5-20	71		4,575
16	stained glass, storage doors, patio	1994		20,337	857	20-30	857		7,093
17	door magnets, outside sign, exhaust fan	1995		5,306	275	5-20	275		3,176
18	Alzheimers building	1996		1,520,446	61,013	7-40	61,013		249,431
19	fire alarm, compressor, courtyard, pc kitchen	1997		59,487	6,624	7-40	6,624		37,809
20	painting, carpeting, lighting	1998		107,411	10,252	7-20	10,252		44,140
21	air conditioner, irrigation system, nursing station	1999		245,492	14,068	5-20	14,068		47,337
22	chiller, security system, blacktop	2000		64,041	4,953	5-20	4,953		11,145
23	carpeting, heat exchanger, painting	2001		50,995	723	7-20	723		4,492
24	carpeting, wall panels, hvac controls	2002		129,498	5,379	7-20	5,379		5,379
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar									
1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,089,972	\$ 184,421		\$ 184,421	\$	\$ 2,139,517	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Willows Health Center

0020792

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,330,864	\$ 66,448	\$ 66,448	\$	5-20	\$ 1,090,003	71
72	Current Year Purchases	60,615	2,855	2,855		7-20	2,855	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,391,479	\$ 69,303	\$ 69,303	\$		\$ 1,092,858	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,503,187	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 253,724	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 253,724	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,232,375	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2003 \$ _____

13. _____/2004 \$ _____

14. _____/2005 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (832,896)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	294,082		3
4	Supply Inventory (priced at cost)	40,070		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,065		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (494,679)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,736		13
14	Buildings, at Historical Cost	6,089,972		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,391,479		16
17	Accumulated Depreciation (book methods)	(3,232,375)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	162,771		21
22	Other Long-Term Assets (specify Investment)	710		22
23	Other(specify): Receivable from affiliate	66,288		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,500,581	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,005,902	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 145,528	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,504		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 256,032	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 256,032	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,749,870	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,005,902	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,932,407	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,932,407	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(187,257)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Temporary restricted	4,720	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (182,537)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,749,870	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Willows Health Center

0020792

Report Period Beginning: 07/01/01

Ending:

Page 19

06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,668,607	1
2	Discounts and Allowances for all Levels	(184,164)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,484,443	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	141,060	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 141,060	23
D. Non-Operating Revenue			
24	Contributions	4,567	24
25	Interest and Other Investment Income***	5,816	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,383	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Realized and unrealized Gains (Losses)	(13,518)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (13,518)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,622,368	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,878,309	31
32	Health Care	2,623,415	32
33	General Administration	964,415	33
B. Capital Expense			
34	Ownership	275,786	34
C. Ancillary Expense			
35	Special Cost Centers	17,877	35
36	Provider Participation Fee	49,823	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,809,625	40
41	Income before Income Taxes (line 30 minus line 40)**	(187,257)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (187,257)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Willows Health Center

0020792

Report Period Beginning: 07/01/01

Ending:

06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 52,000	\$ 25.00	1
2	Assistant Director of Nursing	2,000	2,080	41,000	19.71	2
3	Registered Nurses	14,000	14,560	337,869	23.21	3
4	Licensed Practical Nurses	22,000	22,880	597,160	26.10	4
5	Nurse Aides & Orderlies	86,000	89,440	1,117,078	12.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,000	10,800	110,593	10.24	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	1,000	1,040	16,640	16.00	12
13	Food Service Supervisor	2,000	2,080	24,960	12.00	13
14	Head Cook	1,000	1,040	10,400	10.00	14
15	Cook Helpers/Assistants	40,000	41,600	363,897	8.75	15
16	Dishwashers	8,000	8,320	56,160	6.75	16
17	Maintenance Workers	12,000	12,480	171,575	13.75	17
18	Housekeepers	14,000	14,560	145,594	10.00	18
19	Laundry	8,000	8,320	69,755	8.38	19
20	Administrator	1,000	1,040	39,600	38.08	20
21	Assistant Administrator					21
22	Other Administrative	1,500	1,560	63,608	40.77	22
23	Office Manager					23
24	Clerical	8,000	8,320	78,347	9.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	450	450	24,191	53.76	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	14,000	14,560	149,623	10.28	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) HR & Marketing	4,000	4,160	42,200	10.14	33
34	TOTAL (lines 1 - 33)	250,950	261,370	\$ 3,512,250 *	\$ 13.44	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	450	24,191	9-1	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	450	\$ 24,191		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	9,780	119,810	10-1	52
53	TOTAL (lines 50 - 52)	9,780	\$ 119,810		53

Facility Name & ID Number Willows Health Center# 0020792Report Period Beginning: 07/01/01Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description			Description	Amount
Bill Pratt	CEO	0	\$ 36,878	Workers' Compensation Insurance	\$ 5,000		IDPH License Fee	\$
Terry Kurzinski	CFO	0	26,730	Unemployment Compensation Insurance	45,752		Advertising: Employee Recruitment	
Vicki Toelke	Administrator	0	39,600	FICA Taxes	248,329		Health Care Worker Background Check (Indicate # of checks performed <u>50</u>)	500
				Employee Health Insurance	340,632		Subscriptions	104
				Employee Meals	4,201		Dues	7,991
				Illinois Municipal Retirement Fund (IMRF)*				
				403b RETIREMENT PLAN	14,652			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 103,208					
B. Administrative - Other								
Description			Amount					
			\$ 0					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
II Dept of Public Health	Medicare Survey	\$ 4,300		N/A		\$ 0	Out-of-State Travel	\$
IBM / Xerox	Copiers	5,183						
Xerox	Copiers	1,750						
Iron Mountain	Shredding	776					In-State Travel	1,732
Williams McCarthy	Legal Fees	414						
Wesley Willows	Mgt Fee	4,200					Mileage Reimbursement	657
McGladrey & Pullen	Audit Fees	7,236					Seminar Expense	0
Entre	Computers	16,853						
							Continuing Education	1,160
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 40,712	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,549

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number Willows Health Center

STATE OF ILLINOIS

0020792

Report Period Beginning:

07/01/01

Ending:

Page 23

06/30/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. AAHSA,LSN, United Med
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,480 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 49,823
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 4,201 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V LINE 7 EQUALS COST OF HR AND MARKETING DEPTS

SCHEDULE V LINE 24 (TRAVEL AND SEMINAR) DETAILS ATTACHED

TRAVEL	\$ 1,732
MILEAGE REIMBURSEMENT	657
CONTINUING EDUCATION	1,160
TOTAL	<u>\$ 3,549</u>

SCHEDULE V LINE 27 (MISCELLANEOUS) DETAILS ATTACHED

PAYROLL PROCESSING	\$ 8,042
TEMPORARY HELP	7,983
CABLEVISION	9,346
RESIDENT REPLACEMENTS	2,314
MISCELLANEOUS	(1,138)
GOLDEN EAGLE / INCENTIVE	4,783
BACKGROUND CHECKS	500
TOTAL	<u>\$ 31,830</u>

SCHEDULE V RECLASSIFICATIONS

RECLASS EMPLOYEE MEALS FROM FOOD PURCHASE TO EMPLOYEE BENEFITS

FROM LINE 2 TO LINE 22 \$ 4,201

RECLASS BACKGROUND CHECKS FROM HR TO DUES & FEES

FROM LINE 15 TO LINE 20 \$ 500

RECLASS BEAUTY SHOP COSTS FROM NURSING TO SPECIAL COSTS

FROM LINE 10 TO LINE 40 \$ 3,151

WILLOWS HEALTH CENTER 0020792

7/01/2001 TO 6/30/2002

SCHEDULE V LINE 43

DEVELOPMENT COSTS INCLUDE COST TO RAISE CONTRIBUTIONS

PAGE 21 , SECTION C LEGAL FEES

LEGAL FEES ARE UNDER \$2,500

PAGE 26

WILLOWS HEALTH CENTER 0020792

7/01/2001 TO 6/30/2002

SCHEDULE XIII, SECTION A1

NO TRAINING COSTS

AIDES ARE TRAINED AT THE LOCAL COMMUNITY COLLEGE,

ROCK VALLEY COMMUNITY COLLEGE

PAGE 27